MEDICA®

Medica Group Advantage Solution℠

Summary of Benefits

for H2409-801/H2410-801
January 1 – December 31, 2009

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Section I:

Introduction to the Summary of Benefits for Medica Group Advantage Solution℠ January 1 – December 31, 2009

Thank you for your interest in Medica Group Advantage Solution℠. Our plan is offered by Medica Health Plans, a Medicare Advantage Private Fee-for-Service organization. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Medica Health Plans and ask for the "Evidence of Coverage."

You Have Choices In Your Health Care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare Advantage Private Fee-for-Service plan, like Medica Group Advantage Solution.

You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare program.

You may join or leave a plan only at certain times. Please call Medica at the number listed at the end of this introduction, your benefits department or call **1-800-MEDICARE (1-800-633-4227)** for more information. TTY users should call **1-877-486-2048.** You can call 24 hours a day, 7 days a week.

How Can I Compare My Options?

You can compare Medica Group Advantage Solution and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

Where Is Medica Group Advantage Solution Available?

The Medica Group Advantage Solution service area is all 50 U.S. states and territories provided the Employer Group meets certain eligibility requirements.

Who Is Eligible To Join Medica Group Advantage Solution?

You can join Medica Group Advantage Solution if:

- You meet the eligibility requirements established by the group plan sponsor.
- You are enrolled in Medicare Parts A and B.
- You continue to pay your Medicare Part B premium.
- You do not have End-Stage Renal Disease (ESRD), unless:

  1) You are already enrolled in a Medica plan as a non-Medicare member and you developed ESRD while a Medica member; or

  2) You have had a successful kidney transplant and no longer require dialysis; or

  3) You are medically determined to first have ESRD **after** the date you elect Medica Group Advantage Solution, **but before** the effective date of coverage under the plan. (The date you elect Medica Group Advantage Solution is the date the enrollment form is signed, the receipt date stamp if no date is on the form, or the date election is made by alternate means provided by CMS.)

Can I Choose My Doctors?

As a member of Medica Group Advantage Solution, you can use any Medicare doctor, specialist, or hospital that accepts Medicare payment and accepts the terms, conditions and payment rate of the Medica Health Plans plan. Medica Health Plans has the right to determine if the service or treatment ordered by your health care provider is covered under the Medica Health Plans plan. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide healthcare services to you, except in emergencies.

Does My Plan Cover Medicare Part B or Part D Drugs?

Medica Group Advantage Solution does cover Medicare Part B prescription drugs. It also covers Medicare Part D prescription drugs.

Where Can I Get My Prescriptions If I Join This Plan?

Medica Group Advantage Solution has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a current Pharmacy Network List or visit us at www.medica.com. Our customer service number is listed at the end of this introduction.

What is a Prescription Drug Formulary?

Medica Group Advantage Solution uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at **www.medica.com** .

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

How Can I Get Extra Help With Prescription Drug Plan Costs?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join Medica Group Advantage Solution, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

What Are My Protections in This Plan?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

What Are My Protections Under the Medica Part D Plan?

As a member of Medica Group Advantage Solution, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

What Is A Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Medica Group Advantage Solution for more details.

What Types of Drugs May Be Covered Under Medicare Part B?

The following outpatient prescription drugs may be covered under Medicare Part B. This may include, but is not limited to, the following types of drugs. Contact Medica Group Advantage Solution for more details.

- **Some Antigens:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis Drugs:** Injectable drugs for osteoporosis for certain women with Medicare.
- **Erythropoietin (Epoetin alpha or Epogen®):** By injection if you have End-Stage Renal Disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable Drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen. Inhalation and infusion drugs provided through DME.

Please call Medica Health Plans for more information about this plan. Visit us at www.medica.com or call us:

Customer Service Hours: 8 a.m. to 8 p.m., CST, seven days a week. Please note that access to a representative is limited on the weekends/holidays during certain times of the year.

Current members should call 952-992-2330 (TTY: 952-992-3650) or 1-800-575-2330 (TTY: 1-800-234-8819)

Prospective members should call 952-992-2330 (TTY: 952-992-3650) or 1-800-575-2330 (TTY: 1-800-234-8819)

For questions related to the Medicare Part D Prescription Drug program

Current members should call 1-800-575-2330 (TTY: 1-800-234-8819) prospective members should call 1-800-575-2330 (TTY: 1-800-234-8819).

For more information about Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week; or visit www.medicare.gov on the Web.

If you have special needs, this document may be available in other formats.

Section II:

Summary of Benefits for Medica Group Advantage Solution℠ for
If you have any questions about this plan's benefits or costs, please contact

Benefit	Original Medicare
IMPORTANT INFORMATION	
1. **Premium and Other Important Information**	• You pay the Medicare Part B premium of $96.40 each month. Most people will pay the standard monthly Part B premium. However, starting January 1, 2009, some people will have to pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information on Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
2. **Doctor and Hospital Choice** (for more information, see Emergency Care - #15 and Urgently Needed Care - #16)	• You may go to any doctor, specialist or hospital that accepts Medicare.
INPATIENT CARE	
3. **Inpatient Hospital Care** (includes Substance Abuse and Rehabilitation Services)	• You pay for each benefit period (3): Days 1 60: an initial deductible of $1,068. Days 61 90: $267 each day. Days 91 150: $534 each lifetime reserve day. (4) Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. (4)
4. **Inpatient Mental Health Care**	• You pay the same deductible and copayments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.

(1) Each year, you pay a total of one $135 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.
(3) A benefit period starts the day you are admitted into a hospital or skilled nursing facility. It ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted into the hospital after one

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- You continue to pay the Medicare Part B premium of $96.40 each month.
- You pay a deductible of $200 every year for medical services. You also pay a $200 prescription drug deductible every year.
- There is a $3000 maximum out-of-pocket limit every year for all covered plan services.
- There is a $3000 maximum out-of-pocket limit every year for prescription drugs and pharmacy services including insulin. These prescription drug out-of-pocket expenses also apply toward the annual out-of-pocket maximum for all other covered health services.
- Medicare excluded medications are not included in the accumulation of maximum out of pocket.

- You may go to any doctor, specialist or hospital that accepts the plan's payment.
- A separate doctor office visit copayment may apply for certain services.

- Deductible applies.
- You pay $100 for each Medicare-covered stay at a hospital.
- There is no copayment for additional days received at a hospital.
- You are covered for unlimited days each benefit period.
- You may go to any doctor, specialist or hospital that accepts the plan's payment.

- Deductible applies.
- You pay $100 for each Medicare-covered stay at a hospital.
- There is no copayment for additional days received at a hospital.
- Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.
- There is no copayment for an additional 175 lifetime days in a Medicare-eligible Psychiatric Hospital once you have exhausted the Medicare limit of 190 days.
- You may go to any doctor, specialist or hospital that accepts the plan's payment.

benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible, if applicable, for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact

Benefit	Original Medicare
INPATIENT CARE (CONTINUED)	
5. Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	• You pay for each benefit period (3), following at least a three-day covered hospital stay: Days 1 20: $0 for each day. Days 21 100: $133.50 for each day. • There is a limit of 100 days for each benefit period. (3)
6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services,etc.)	• You pay nothing for all covered home health visits.
7. Hospice	• You pay part of the cost for outpatient drugs and inpatient respite care. • You must receive care from a Medicare-certified hospice.
OUTPATIENT CARE	
8. Doctor Office Visits	• You pay 20% of Medicare-approved amounts. (1) (2)
9. Chiropractic Services	• You pay 20% of Medicare-approved amounts. (1) (2) • You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers. • You pay 100% for routine care.

(1) Each year, you pay a total of one $135 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.
(3) A benefit period starts the day you are admitted into a hospital or skilled nursing facility. It ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted into the hospital after one

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- You pay nothing for Medicare-covered services received at a Skilled Nursing Facility.
- No prior hospital stay is required.
- You are covered for 100 days each benefit period. (3)

- You pay nothing for each Medicare-covered home health visit.

- You must receive care from a Medicare-certified hospice.

- Deductible applies.
- You pay $20 for each primary care doctor office visit for Medicare-covered services.
- You pay $20 for each specialist visit for Medicare-covered services.
- You may go to any doctor, specialist or hospital that accepts the plan's payment.
- See item 33 Physical Exams for more information.

- Deductible applies.
- You pay $20 for each Medicare-covered visit.
- Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.
- You may go to any doctor, specialist or hospital that accepts the plan's payment.

benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible, if applicable, for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

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Benefit	Original Medicare
OUTPATIENT CARE (CONTINUED)	
10. Podiatry Services	• You pay 20% of Medicare-approved amounts. (1) (2) • You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs. • You pay 100% for routine care.
11. Outpatient Mental Health Care	• You pay 50% of Medicare-approved amounts for most outpatient mental health services. (1) (2)
12. Outpatient Substance Abuse Care	• You pay 20% of Medicare-approved amounts. (1) (2)
13. Outpatient Services/Surgery	• You pay 20% of Medicare-approved amounts for the doctor. (1) (2) • You pay 20% of outpatient facility charges. (1) (2)
14. Ambulance Services (medically necessary ambulance services)	• You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1) (2)
15. Emergency Care (you may go to any emergency room if you reasonably believe you need emergency care)	• You pay 20% of the facility charge or a set copay for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within three days of the emergency room visit. (1) (2) • You pay 20% of doctor charges. (1) (2) • NOT covered outside the U.S. except under limited circumstances.
16. Urgently Needed Care (this is NOT emergency care)	• You pay 20% of Medicare-approved amounts or a set copay. (1) (2) • NOT covered outside the U.S. except under limited circumstances.

(1) Each year, you pay a total of one $135 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.
(3) A benefit period starts the day you are admitted into a hospital or skilled nursing facility. It ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted into the hospital after one

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- Deductible applies.
- You pay $20 for each Medicare-covered visit.
- Medicare-covered podiatry services are for medically-necessary foot care.
- You may go to any doctor, specialist or hospital that accepts the plan's payment.

- Deductible applies.
- You pay $20 for Medicare-covered Mental Health services, for each individual/group therapy visit.
- You may go to any doctor, specialist or hospital that accepts the plan's payment.

- Deductible applies.
- You pay $20 for Medicare-covered services, for each individual/group visit.
- You may go to any doctor, specialist or hospital that accepts the plan's payment.

- Deductible applies.
- You pay nothing for each Medicare-covered doctor service.
- You pay nothing for each Medicare-covered visit to an outpatient hospital facility or ambulatory surgical center.
- You may go to any doctor, specialist or hospital that accepts the plan's payment.

- Deductible applies.
- You pay $25 per transport for Medicare-covered ambulance services.

- Deductible applies.
- You pay $50 for each Medicare-covered emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 24 hours.
- Worldwide coverage.

- Deductible applies.
- You pay $20 for each Medicare-covered urgently needed care visit at an after-hours clinic.
- You pay $50 for each Medicare-covered urgently needed care visit at an emergency room.
- NOT covered outside the U.S. except under limited circumstances.
- You may go to any doctor, specialist or hospital that accepts the plan's payment.

benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible, if applicable, for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact

Benefit	Original Medicare
OUTPATIENT CARE (CONTINUED)	
17. **Outpatient Rehabilitation Services** (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	• You pay 20% of Medicare-approved amounts. (1) (2) • Effective January 1, 2009, there is a $1,810 maximum benefit for Physical Therapy and Speech Therapy and a separate $1,810 maximum benefit for Occupational Therapy. These limits apply to all outpatient therapy services, except hospital outpatient therapy services. They do apply to therapy services in Skilled Nursing Facilities.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES	
18. **Durable Medical Equipment** (includes wheelchairs, oxygen, etc.)	• You pay 20% of Medicare-approved amounts. (1) (2)
19. **Prosthetic Devices** (includes braces, artificial limbs and eyes, etc.)	• You pay 20% of Medicare-approved amounts. (1) (2)
20. **Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies** (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	• You pay 20% of Medicare-approved amounts. (1) (2) • Nutrition Therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietician or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.

(1) Each year, you pay a total of one $135 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.
(3) A benefit period starts the day you are admitted into a hospital or skilled nursing facility. It ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted into the hospital after one

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- Deductible applies.
- You pay $20 for each Medicare-covered Occupational Therapy visit.
- You pay $20 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.
- Effective January 1, 2009, there is a $1,810 maximum benefit for Physical Therapy and Speech Therapy and a separate $1,810 maximum benefit for Occupational Therapy. These limits apply to all outpatient therapy services, except hospital outpatient therapy services. They do apply to therapy services in Skilled Nursing Facilities.

- Deductible applies.
- You pay 20% of the cost for each Medicare-covered item.

- Deductible applies.
- You pay 20% of the cost for each Medicare-covered item.

- Deductible applies.
- You pay 20% of the cost for Medicare-covered Diabetes self-monitoring training.
- You pay 20% of the cost for Medicare-covered Diabetes Nutrition Therapy.
- You pay 20% of the cost for each Medicare Part B-covered Diabetes Supply item.

benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible, if applicable, for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact

Benefit	Original Medicare
OUTPATIENT MEDICAL SERVICES AND SUPPLIES (CONTINUED)	
21. Diagnostic Tests, X-Rays, and Lab Services	• You pay 20% of Medicare-approved amounts, except for approved lab services. (1) (2) • You pay nothing for Medicare-approved lab services. • Lab services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.
PREVENTIVE SERVICES	
22. Bone Mass Measurement (for people with Medicare who are at risk)	• You pay 20% of Medicare-approved amounts. (1) (2) • Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.
23. Colorectal Screening Exams (Annual Screening) (for people with Medicare age 50 and older)	• You pay 20% of Medicare-approved amounts. (1) (2) • Covered when you are high risk or when you are age 50 and older.
24. Immunizations (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)	• You pay nothing for the Pneumonia and Flu vaccines. • You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1) (2) • You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.

(1) Each year, you pay a total of one $135 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.
(3) A benefit period starts the day you are admitted into a hospital or skilled nursing facility. It ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted into the hospital after one

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- Deductible applies.
- You pay nothing for the following Medicare-covered service(s):
  - Lab services
  - Diagnostic procedures and tests
  - X-rays
  - Diagnostic radiology services (not including X-rays)
  - Therapeutic radiology services
- Doctor office visit copayment/coinsurance may apply.
- You may go to any doctor, specialist or hospital that accepts the plan's payment.

- Deductible does not apply.
- You pay nothing for each Medicare-covered Bone Mass Measurement.
- You may go to any doctor, specialist or hospital that accepts the plan's payment.

- Deductible does not apply.
- You pay nothing for each Medicare-covered Colorectal Screening Exam.
- You may go to any doctor, specialist or hospital that accepts the plan's payment.

- Deductible does not apply.
- You pay nothing for the Pneumonia and Flu vaccines.
- You pay nothing for the Hepatitis B vaccine.
- Doctor office visit copayment may apply.
- You may go to any doctor, specialist or hospital that accepts the plan's payment.

benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible, if applicable, for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

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Benefit	Original Medicare
PREVENTIVE SERVICES (CONTINUED)	
25. Mammograms (Annual Screening) (for women with Medicare age 40 and older)	• You pay 20% of Medicare-approved amounts. (2) • Covered once a year for all women with Medicare, age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39. • No referral necessary for Medicare-covered screenings.
26. Pap Smears and Pelvic Exams (Annual Screening) (for women with Medicare)	• You pay nothing for a Pap Smear once every two years, annually for beneficiaries at high risk. (2) • You pay 20% of Medicare-approved amounts for Pelvic Exams. (2)
27. Prostate Cancer Screening Exams (Annual Screening) (for men with Medicare age 50 and older)	• There is no copayment for the PSA test and a copayment of 20% of Medicare-approved amounts for the digital rectal exam and other related services. (2) • Covered once a year for all men with Medicare over age 50.
28. End-Stage Renal Disease (ESRD)	• You pay 20% of the cost for Medicare-covered dialysis. (1) (2) • You pay 20% of the cost for Medicare-covered Nutritional Therapy for End-Stage Renal Disease. • Nutrition Therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietician or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.

(1) Each year, you pay a total of one $135 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.
(3) A benefit period starts the day you are admitted into a hospital or skilled nursing facility. It ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted into the hospital after one

Medica at 952-992-2330 or 1-800-575-2330.

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	• Deductible does not apply. • You pay nothing for Medicare-covered Screening Mammograms. • You may go to any doctor, specialist or hospital that accepts the plan's payment.
	• Deductible does not apply. • You pay nothing for one routine Medicare-covered Pap Smear and Pelvic Exam per year. • You may go to any doctor, specialist or hospital that accepts the plan's payment.
	• Deductible does not apply. • You pay nothing for Medicare-covered prostate cancer screening exams. • You may go to any doctor, specialist or hospital that accepts the plan's payment.
	• Deductible does not apply. • You pay nothing for Medicare-covered dialysis. • You pay 20% of the cost for Medicare-covered Nutrition Therapy for Renal Disease. • You may go to any doctor, specialist or hospital that accepts the plan's payment.

benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible, if applicable, for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact

Benefit	Original Medicare
ADDITIONAL BENEFITS (What Original Medicare Does Not Cover)	
29. **Outpatient Prescription Drugs** **Drugs Covered Under Medicare Part D (Prescription Drug Benefit)**	• Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage. • You pay 100% for most prescription drugs.
General Information	

(1) Each year, you pay a total of one $135 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.
(3) A benefit period starts the day you are admitted into a hospital or skilled nursing facility. It ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted into the hospital after one

Medica at 952-992-2330 or 1-800-575-2330.

Medica Group Advantage Solution

Drugs Covered Under Medicare Part B

General

- You pay 20% of the cost for Medicare Part B-covered drugs (including Part B-covered chemotherapy drugs).

- This plan uses a closed formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary changes that limit our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you upon request or you can see our complete formulary on our Web site at www.medica.com .
- People who have limited incomes, who live in a long-term care facility, or who have access to Indian/Tribal/Urban (Indian Health Service) facilities, may have different out-of-pocket drug costs. Contact plan for details.
- Coverage will not be provided for prescription drugs that are not on the Medica closed drug formulary.
- The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).
- Covered Part D drugs are available at out-of-network pharmacies in special circumstances, including illness while traveling outside of the plan's service area where there is no network pharmacy.
- Prescription drugs must be received from network retail pharmacies or designated mail order pharmacy for your benefits to apply.
- For prescription drugs and pharmacy services, you have an annual out-of-pocket maximum of $3000. Once you have paid $3000 in Medicare Part D eligible deductibles and copayments, your prescription drugs will be covered at 100% for the remainder of the calendar year.
- These prescription drug out-of-pocket expenses also apply toward the annual out-of-pocket maximum for all other plan services under the Medica Group Advantage Solution plan.
- In some cases, the plan requires you to first try one or two drugs to treat your medical condition before they will cover another drug for that condition.
- Certain prescription drugs may have maximum quantity limits.
- Your provider may need to get prior authorization from Medica Group Advantage Solution for certain prescription drugs.
- You may need to go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in the network. These drugs are listed on the plan's Web site, formulary, and printed material.
- Please contact the plan for details.

benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible, if applicable, for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact

Benefit	Original Medicare
ADDITIONAL BENEFITS (What Original Medicare Does Not Cover) (CONTINUED)	
29. Outpatient Prescription Drugs **Drugs Covered Under Medicare Part D (Prescription Drug Benefit) (continued)**	• You pay 100% for most prescription drugs.
Deductible	
Retail Pharmacy	
Mail Order	
30. Dental Services	• You pay 100% for dental services (such as cleaning).
31. Hearing Services	• You pay 100% for routine hearing exams and hearing aids. • You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1) (2)

(1) Each year, you pay a total of one $135 deductible.
(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.
(3) A benefit period starts the day you are admitted into a hospital or skilled nursing facility. It ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted into the hospital after one

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- Deductible applies.
- There is a $200 prescription drug deductible in addition to the deductible for other medical expenses under your Medica Group Advantage Solution plan. Your deductible is the amount that you must pay for covered drugs each calendar year before this plan begins paying for part of your drug costs.

- You pay the following for covered prescription drugs:

  $15 for a one-month (31 day) supply of Formulary Generic (Tier 1) drugs you get at a network pharmacy.
  $30 for a one-month (31 day) supply of Formulary Brand-name (Tier 2) drugs you get at a network pharmacy.

  $45 for a three-month (93 day) supply of Formulary Generic (Tier 1) drugs you get at a network pharmacy.
  $90 for a three-month (93 day) supply of Formulary Brand-name (Tier 2) drugs you get at a network pharmacy.

- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the lesser amount.

- Deductible applies.
- You pay the following for covered prescription drugs:
  $30 for a three-month (93 day) supply of Formulary Generic (Tier 1) drugs you get at a designated mail order pharmacy.
  $60 for a three-month (93 day) supply of Formulary Brand-name (Tier 2) drugs you get at a designated mail order pharmacy.

- Deductible applies.
- In general, you pay 100% for dental services (such as cleaning).
- You pay 20% of the cost for accident-related dental services.

- Deductible applies.
- You pay nothing for each routine hearing test up to one test every year.
- You pay nothing for each fitting evaluation(s) for a hearing aid every year.
- You pay $20 for each Medicare-covered diagnostic hearing exam.
- You pay 100% for hearing aids.
- You may go to any doctor, specialist or hospital that accepts the plan's payment.

benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible, if applicable, for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

If you have any questions about this plan's benefits or costs, please contact

Benefit	Original Medicare
ADDITIONAL BENEFITS (What Original Medicare Does Not Cover) (CONTINUED)	
32. Vision Services	• You pay 100% for routine eye exams and glasses. • You pay 20% of Medicare-approved amounts for diagnosis and treatment for diseases and conditions of the eye. (1) (2) • You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1) (2) • For people with Medicare who are at risk, you are covered for annual glaucoma screenings. (1) (2)
33. Physical Exams	• When you get Medicare Part B, you can receive a one-time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests. • You pay 20% for one exam within the first 12 months of your new Medicare Part B coverage. (1) (2) • You pay 100% for routine physical exams except as listed above.
34. Health/Wellness Education	• You pay 100%. • Smoking Cessation: covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medication that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.(1) (2)
35. Transportation (Routine)	• You pay 100%.
36. Acupuncture	• You pay 100%.

(1) Each year, you pay a total of one $135 deductible.

(2) If a doctor or supplier does not accept assignment, their costs are often higher, which means you may pay more.

(3) A benefit period starts the day you are admitted into a hospital or skilled nursing facility. It ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted into the hospital after one

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- Deductible applies.
- You pay nothing for routine eye exams up to one visit every year.
- You pay $20 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye).
- You pay 20% of the cost for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery).
- You pay 100% for routine glasses.
- You may go to any doctor, specialist or hospital that accepts the plan's payment.

- Deductible does not apply.
- You pay nothing for routine physical exams.
- You are covered for one exam every year.
- You may go to any doctor, specialist or hospital that accepts the plan's payment.

- You pay nothing for the following:
  - Written health education materials, including newsletters
  - SilverSneakers® Fitness Program
  - Medica CallLink® nurse line
  - Smoking Cessation Program

- You pay 100% for routine transportation.

- You pay 100% for Acupuncture.

benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible, if applicable, for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

SECTION III:

Medica's Mission

Our mission is to meet our customers' needs for health plan products and services. In doing so, we work with members and providers to make health care accessible, affordable and a means by which our members improve their health.

Medica Group Advantage Solution℠

Medica Group Advantage Solution is offered to all Medicare-eligible individuals who meet Medica's and their Employer Group's eligibility criteria. Medica Group Advantage Solution is a Medicare Advantage (MA) Private Fee-for-Service plan. This means that you may see any Medicare-approved medical provider that accepts Medica's payment for the services you receive. You are not restricted to a network or service area.

No Coverage

1) Prescription Drugs except those covered by Medicare Part B or specifically included in your Medica Group Advantage Solution plan.
2) Eye wear, except as covered by Medicare or specifically provided under your Medica Group Advantage Solution plan.
3) Personal comfort items during a hospital stay.
4) Private duty nursing.
5) Custodial or maintenance care in a nursing home.
6) Acupuncture.
7) Non-emergency transportation, except as covered by Medicare.
8) Any health service that does not meet Medicare criteria for coverage, except those specifically listed as covered in your Evidence of Coverage.

This is a partial listing. See your Evidence of Coverage for a complete listing of noncovered services.

Health Improvement, Health Management, Utilization Management and Disease Prevention

Medica strives to improve member health outcomes. We do this by developing disease management programs and preventive health programs/initiatives.
We also manage the use of resources for positive outcomes for our members.

Medica's health management and health improvement programs actively work to improve the health, functional status and quality of life of members with chronic conditions. Currently our programs include Medica's Tobacco Cessation Program (a telephone tobacco cessation counseling program), SilverSneakers® Fitness Program (available at selected sites), pneumococcal and influenza prevention through immunizations, and breast cancer prevention.

Medica's disease management guidelines are reviewed regularly to ensure they reflect the most current national standards of care. Medica's programs also seek to identify members at high risk for developing specific health problems and designs a management plan based on their individual needs. Interventions may include removing barriers to care (language barriers), educating members and physicians, and coordinating member treatment plans with their health care providers.

Medica CallLink®

Because your health care needs do not always follow regular business hours, Medica CallLink is an easy-to-use phone service staffed by registered nurses 24 hours a day, seven days per week. Medica CallLink is a valuable health information resource that can help you find the medical care you need quickly. With one call, the nurses of CallLink instruct you on the care of minor illnesses and injuries at home, and help you find a doctor near your home if necessary. An extensive health and wellness audio tape library is also part of this service.

Medica CallLink: 1-866-715-0915

Hearing impaired members, call the National Relay Station at 1-800-855-2880 and request Medica CallLink at 1-866-715-0915.

Contact Us

For more information on Medica Medicare Solutions® plans, call **952-992-2330** or **1-800-575-2330** . TTY users may call **952-992-3650** or **1-800-234-8819.**

Hours of operation:

8 a.m. to 8 p.m., CST, seven days a week. Please note that access to a representative is limited on the weekends/holidays during certain times of the year.

Visit us on the web at **www.medica.com** .

Medica Privacy Notice

Medica takes its responsibility of protecting your personal information seriously. Where possible, Medica de-identifies or encrypts personal information. We use and disclose personal information only to the extent necessary to conduct treatment, payment and health care operations, or to comply with legal, regulatory or accreditation requirements.

Medica and its business associates obtain, maintain, use and share personal information to carry out certain routine activities. Routine activities include: (i) treatment-related activities, such as referring you to a doctor or other provider; (ii) payment-related activities, such as paying a claim for medical services rendered; and (iii) health care operations, such as professional peer review.

The law also gives you rights to access, copy, and amend your personal information. You have the right to request restrictions on certain uses and disclosures of your personal information. You also have the right to obtain information about how and when your personal information has been used and disclosed. Medica's full Privacy Notice is available upon request.

Notes

Notes

MEDICA®

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